OAKLAND COUNTY MICHIGAN
HEALTH DIVISION

OAKLAND COUNTY EXECUTIVE DAVID COULTER

Joanna J. Overall, Manager
(248) 858-1151 | village@oakgov.com

MEDICAL HISTORY

Resident's Name: _____ D.O.B.: _____

Age _____ Male: _____ Female: _____ Resident's Social Security #: _____

Mother: _____ Phone: _____

Address: _____

Father: _____ Phone: _____

Address: _____

Legal Guardian(s) Information: Name: _____

Legal Guardian's Relationship to Child: _____

Address: _____ Phone: _____

In case of emergency notify: Name: _____

Relationship to Child: _____ Phone: _____

Address: _____

Health Insurance Information: Health Insurance Company _____

Contract / ID Number: _____ Group Number: _____

Prescription Coverage Information: _____

Subscriber's Name on Insurance Card: _____

Medicaid ID Number: _____ Subscriber: _____

Children's Special Health Care Services: No ☐ Yes ☐ If Yes, CSHCS Number: _____

Please check any of the below that your child has had:

Drug Overdose		Substance Abuse		Nervous Disorder		Suicide Gestures	
Red or Hard Measles		Shortness of Breath		Frequent Headaches		Seizures	
German or 3 Day Measles		Heart Trouble		Frequent Diarrhea		Epilepsy	
Scarlet Fever		Rheumatic Fever		Frequent Constipation		Hearing Loss	
Whooping Cough		Strep Infection		Pregnancy		High Blood Pressure	
Mumps		Bone / Joint Problem		History of Heart Murmur		Menstrual Problems	
Chicken Pox		Hepatitis		Meningitis		STD's	
Diabetes		Eye Problems		Bed Wetting		AIDS / HIV	

Provide details of any conditions listed above or other conditions not listed: _____

Is child able to take part in normal sports, school activities, gym class? Yes ☐ No ☐ If No, please explain below:

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Has child even been injured, hospitalized or had operations? No ☐ Yes ☐ If Yes, please explain below:

Has child been under a physician's care in the last 12 months? No ☐ Yes ☐ If Yes, please explain below:

Physician's Name _____ Phone Number: _____

Does your child wear glasses? No ☐ Yes ☐ If Yes, are the glasses with the child? _____

Does your child wear hearing aids? No ☐ Yes ☐ If Yes are the hearing aids with the child? _____

Does child have any allergies? No ☐ Yes ☐ If Yes, please list allergies: _____

If any food allergies, please describe what happens: _____

Does child have special diet needs? No ☐ Yes ☐ If Yes, please state dietary needs: _____

Is child currently on medication? No ☐ Yes ☐ ***If Yes, please list the medication and dosage below***:

Have you brought in medication? No ☐ Yes ☐ ***Please bring in all current medications (Date within 30 days)***

MEDICATION	DOSAGE

Additional Information / Comments: _____

_____ _____

Signature of Parent / Legal Guardian Date